SPECIFIC SITUATIONS IN CONTRACEPTION

RCGP LEARNING

QUICK STARTING

Quick starting if not pregnant	Reasonably sure pregnancy excluded	Quick starting if may be pregnant
• Usual advice to start at beginning of menstrual cycle risks woman not coming back/conceiving before next period. • Any method can be started at any time in the cycle if it is 'reasonably certain that a woman is not pregnant or at risk of pregnancy from recent unprotected intercourse (UPSI)' (FSRH wording).	• No SI since LMP, childbirth, miscarriage, TOP, ectopic or uterine evacuation for gestational trophoblastic disease (GTD). • Consistent/correct use of a reliable method of contraception. • First 5/7 of cycle. • < 21/7 postpartum or ≤ 5/7 post TOP, miscarriage, ectopic or uterine evacuation for GTD. • Fully breastfeeding + amenorrhoeic + < 6/12 postpartum. • No SI for >21/7 + negative pregnancy test.	• EC might be needed. • Any method other than levonorgestrel IUD (LNG-IUD) and cyproterone containing pill can be quick started, but injectable less suitable. • Copper IUD (Cu-IUD) quick start only if criteria for EC are met. • Barrier method/abstinence until new method becomes effective. • Pregnancy test must be done ≥ 21/7 after last UPSI. • No evidence of harm to foetus if contraception inadvertently given in early pregnancy.

EMERGENCY CONTRACEPTION (EC)

Which method?	When can it be given?	Other issues to consider

• Cu-IUD is the most effective – if Cu-IUD planned but can't be done immediately, give oral EC in case of changed mind/IUD can't be inserted.
• Ulipristal (UPA-EC) is more effective than levonorgestrel (LNG-EC) and should be first-line oral method if UPSI likely to have been ≤ 5/7 before ovulation.
• FSRH guidance on EC has useful flowcharts to guide decision making process.
	• UPA-EC up to 120h after UPSI.
	• LNG-EC up to 72h after UPSI.
	• Oral EC ineffective if after ovulation, so consider Cu-IUD in that situation if sure of dates.
	• Oral EC fine if multiple UPSI in same cycle (won't disrupt established pregnancy or be teratogenic).
	• Cu-IUD:
	  ○ Up to 5/7 after first UPSI in a normal cycle.
	  ○ Up to 5/7 after earliest likely date of ovulation (even if multiple UPSI).
		• Reduced effectiveness:
		  ○ Oral EC + enzyme-inducing drugs (use Cu-IUD or double dose LNG-EC).
		  ○ UPA-EC if a progestogen is given within 5/7 after or 7/7 days before the UPA.
		  ○ LNG-EC if weight >70kg or BMI ≥ 26 (use UPA-EC, Cu-IUD or double dose LNG-EC).
		• Contraindications:
		  ○ Asthma on regular oral steroids (UPA-EC).
		  ○ Any usual contraindication for an IUD.

TAILORED REGIMES

What is a tailored regime?	Why use a tailored regime?	Choice of tailored regimes
• Any regime that is other than the licensed 21 days of pill/patch/ring followed by a 7 day hormone-free interval (HFI). • FSRH recommends counselling about both standard and tailored regimes. • Tailored = unlicensed but recommended by FSRH.	• ↓ frequency withdrawal bleed. • ↓ withdrawal symptoms in HFI. • Likely to be more effective as ↓ risk of ovulation with combined hormonal contraception (CHC), though evidence not conclusive. • No evidence of ↑ adverse effects compared to standard regime.	• Shortened HFI – 21/7 CHC + 4/7 HFI. • Tricycling – 63/7 CHC + 4/7 HFI. • Flexible extended use – use CHC until breakthrough bleeding occurs, then have 4/7 HFI. • Continuous – continue to use CHC with no HFI at all.

FSRH QUICK STARTING (2017). FSRH EMERGENCY CONTRACEPTION (2023). FSRH CHC (2023).